WELCOME

Patient Information

Patient Name____________________

Address________________________

City______________Zip_________

Home Phone (___) ______________

Sex: F___M___ Birth Date___________

Last Four SSN___________________

Occupation______________________

Employer________________________

Employer Address________________

City_________ State ____Zip________

Work Phone (___) _______________

Cell (___)_______________________

Eye & Medical Health

Last eye exam ___________________

Name of Doctor__________________

Last medical physical _____________

Name of Doctor__________________

Do you wear glasses? Yes___ No____

All the time___ Occasionally_______

Driving___ TV____ Computer_____

Do you wear contacts? Yes___ No___

Type____________________________

Hours/ Day ______________________

Describe any problems you have with your contacts__________________

E-mail______________________________________

Mark all that apply while wearing prescription glasses or contacts or mark here ___ if not wearing Rx for spectacles and are experiencing which of the following.

Bloodshot eyes	Yes___	No ___	Floaters	Yes___	No___
Blurred Vision- Distance	Yes ___	No ___	Glaucoma	Yes___	No___
Blurred Vision- Near	Yes___	No ___	Headaches	Yes___	No___
Burning Eyes	Yes___	No___	Itching Eyes	Yes____	No___
Cataracts	Yes___	No ___	Light Sensitive	Yes____	No___
Color Vision	Yes ___	No___	Loss of Vision	Yes ___	No___
Diabetes	Yes___	No___	Migraine Headaches	Yes___	No___
Discharge from Eye	Yes___	No___	Night Vision Poor	Yes ___	No___
Dizzy Spells	Yes ___	No___	Red Eyes	Yes____	No___
Double Vision	Yes___	No___	Seeing Halos	Yes___	No___
Dry Eyes	Yes___	No____	Seeing Flashes	Yes___	No___
Eye Infections	Yes___	No___	Temporary Loss of Vision	Yes___	No___
Eye Injury	Yes ___	No___	Twitching Eyelid	Yes____	No___
Eye Strain	Yes___	No___	Vision Poor	Yes ___	No___
Fainting Spells	Yes___	No____	Watering Eyes	Yes ___	No___

Others-Explain____

Insurance Information

Insurance Company____________________ Group #_________________________

Insurance Company Address____

Name of Insured______________________ Last Four #s of Insured SSN__________

DOB of Insured_______________________ Relationship to Insured______________

Person to contact in case of emergency_____________________________________

Phone #______________________________

Whom may we thank for referring you? ____________________________________

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Dr. Hoffman to release any information including the diagnosis and the records of any treatment or examination rendered to child or me during the period of such eye care to third party payer and/or health practitioners. I authorize and request my insurance company to pay directly to Dr. Hoffman otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment for all services rendered on my behalf or my dependents, including finance charges, late fees and/or collection fees if any.

X____

Signature of Patient (or parent if minor) Date